sac, and in resection. If the union be not judged secure and, finally, if peritonitic signs be encountered. To combat the paralytic ileus following operation, the use of opium was diminished and the bowel emptied on the second day by enemata of 100 cubic centimetres of oil, repeated until flatus was manifest. The effect of laxatives tends to increase the secretion of the bowel, thus adding toxins to those septic contents already in the bowel. At times, though, opium is indispensable. Only the severest cases were subjected to anus præternaturalis. The choice favoring resection is ofttimes difficult, since the patient would collapse; on the other hand, too little interference leaning towards artificial anus is also wrong.

Objections to artificial anus are the dangers of peritonitis from afferent loop, possibility of perforation, and the possibility of inanition and the necessity of a difficult second operation, with dangers incident to it. Mortality attendant on artificial anus was 70 per cent.; upon primary resection, 8 per cent.

A particularly frequent complication subsequent to herniotomy is pneumonia of lobular type, not merely an aspiration pneumonia, but pneumonia of embolic origin from septic thrombi of the intestinal loop. Once a peculiar condition was encountered long after herniotomy,—viz., stenosis of the bowel at the site of the relieved strangulation traceable to original inflammatory conditions. The total mortality was 18 per cent. in contrast to 45 per cent. in preantiseptic days, and 36 per cent. in the earliest days of antisepsis.—*Beiträge zur klinischen Chirurgie,* Band xxxi, Heft 2.

MARTIN W. WARE (New York).

BONES AND JOINTS.

I. Operative Treatment of Congenital Dislocation of the Hip. By DR. A. CADWELLA (Bologna). Pursuant to a study and personal observation of seventy-six cases of congenital hip dislocation, the author offers the following suggestion in the treatment of this affection. He has observed some cases born with the dislocation incompletely developed, in which instances there is merely the disposition to a subsequent complete dislocation dependent on abnormal anatomical development of the femur, characterized by an anteversion of the upper end of the femur. Increased intra-uterine pressure is held responsible for these changes of femur and acetabulum. The inward rotation of the flexed knee brings about an inversion of the lower end of the femur and the acetabulum at the same time becomes flattened. If the thigh at the age of walking be extended with the patella pointing to the front, the upper end of the femur appears rotated outward. In this unstable condition the muscles tend to displace the femur, and the acetabulum at the same time becomes flattened. muscle and soft parts tilt the pelvis forward and oblige the femur to wander posteriorly. In the forward type of dislocation the capsule lies between the head and the ilium, and thus becomes intimately adherent to periosteum. The compensatory torsion of the femur at its upper end and the adherent capsule are the greatest obstacles to perfect reduction. The plan of treatment is as follows:

Between the ages of three and twelve the bloodless methods of reduction are practical, and in 53 per cent. the results may be judged as good. The remainder of cases are reluxations not as severe, and are therefore styled transposition. Inward rotation is of service when there is torsion of the upper end of the femur and may be maintained in this position by plaster of Paris or by Schede's apparatus. Extreme degrees of torsion have to be modified by the operative procedure of Schede-Doyen. After reduction of dislocation the thigh is rotated until the neck of the femur is in the frontal plane, then a gold-plated nail is driven through the trochanter in the axis of the neck into the acetabulum. A plaster-of-Paris dressing envelops the thigh and the upper one-third of the leg in flexion. After ten days the lower two-thirds of the plaster is removed and osteotomy of the femur in its lower one-third is performed; the leg is then rotated till the patella points forward. Immobilization then follows for one and one-half months.

If the adherent capsule be the obstacle to reduction, it should be loosened by (extra-articular operation) chiselling it from the periosteum and then reduplicating it by two stitches. This traumatic irritation favors reconstruction of the acetabular ridge. If the capsule has to be divided to facilitate reduction, author's specially constructed lever will be found of service. In instances where the acetabulum has to be hollowed out, the separated capsule should embrace the head of the femur and obviate absolute ankylosis. The incision favored to gain access to the hip is to be made along the anterior border of the tensor vaginæ femoris, and, if necessary, thence along the iliac crest dividing the insertions of the tensor vaginæ femoris, glutæus medius, and glutæus minimus. The wound is not to be drained, but completely closed. —*Zeitschrift für orthopädische Chirurgie,* Band ix, Heft 2.

MARTIN W. WARE (New York).

GENITO-URINARY ORGANS.

I. The Treatment of Prostatic Hypertrophy. By DR. E. GOLDMAN (Freiburg). A new method is herewith presented, which purposes to restore the anatomical relations of the bladder, and thus overcome the mechanical disturbances engendered by enlargement of the prostate,—viz., incontinence and retention. The bases of this operation are the observations of Waldeyer, that, if the bladder be fully distended, the urethra is shortened because of the arrangement of the muscular fibres that go to make up the internal sphincter, and which also give to the bladder a line of direction. When this line of direction is altered by overdistention, retention and overflow ensue.

To overcome these the author has planned at one and the same moment to lift up that part of the bladder which makes up the *bas-fond,* and also to widen the internal urethral orifice by